Rolla Regional Center
EMERGENCY CONTACT FORM

Consumer Name				Case #			
Birthdate			Social Security #				
Medicaid #			Medicare #				
Facility (if ISL, include Provider)							
Address							
Contact Person				Phone #			
Physician Name				Phone #			
Address		City		Zip			
Referral Hospital				Phone #			
Address		City		Zip			
Does Consumer have Health Insurance other than Medicaid/Medicare?				Y		N	
Does Consumer have Life Insurance/Burial Policy?				Y		N	
If yes, name of Insurance Company							
Address							
Policy #		Policyholder Name					
Legal Guardian Name			Relationship				
Address			Phone #				
Family Members in order of contact:							
Name		Relationship					
Address		Phone #					
Name		Relationship					
Address		Phone #					
Name of Funeral Home to be contacted in the event that person has no parent, family or guardian support:							
Name							
Address							
RRC SC		Home Phone #					
Date completed							